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1.0 Description of the Procedure

Craniofacial surgery encompasses a broad spectrum of reconstructive procedures of the cranium and face. The objectives of these procedures are to correct deformities of the face and skull bones that result from birth defects, trauma, or disease and to restore craniofacial form and function by medical and surgical means. Some examples of conditions that may require craniofacial surgery are clefts of the lip and palate, craniosynotosis, hemifacial microsomia, microtia, Pierre Robin syndrome, Apert syndrome, and Crouzon syndrome.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

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****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Procedure Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Craniofacial surgery is covered when it is medically necessary and

a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

a. For craniofacial surgery, "medical necessity" is defined as the reason the procedure is needed to raise a recipient to his or her optimal functioning level or, specific to children, to correct or ameliorate significant congenital craniofacial deformities.

b. The need for surgery must arise from an injury, disease, birth defect, or growth and development that resulted in significant functional impairment.

"Significant functional impairment" may include, but is not limited to

1. Problems with communication
2. Problems with respiration
3. Problems with eating
4. Problems with swallowing
5. Visual impairments

6. Distortion of nearby body parts
7. Obstruction of an orifice

c. Orthognathic surgery prior to craniofacial surgery is provided for persistent difficulties with mastication and swallowing, jaw posturing, temporomandibular joint problems, and malocclusion needing skeletal correction.

See **Attachment A, Claims-Related Information,** for procedure codes that require prior approval.

4.0 When the Procedure Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Craniofacial surgery is not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure unnecessarily duplicates another provider's procedure; or
d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Craniofacial surgery is not covered when it is performed for cosmetic reasons, rather than primarily to restore impairment or correct deformity in children, caused by injury, disease, birth defects, or growth and development.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

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5.1 Prior Approval

Prior approval is required for most procedures or related components of reconstruction. Specific procedures may require additional medical record documentation for prior approval.

The following information must be submitted with each prior approval request:

a. The location and cause of the defect
b. Pre-operative photographs
c. CPT codes describing the procedures to be performed
d. Supporting documentation that the treatment can reasonably be expected to improve the impairment

6.0 Providers Eligible to Bill for the Procedure

Providers who meet Medicaid's qualifications for participation, and are currently enrolled with the N.C. Medicaid program to perform craniofacial surgery, are eligible to bill for these procedures when such procedures are in the scope of their practice.

7.0 Additional Requirements.

7.1 Federal and State Requirements

All providers must comply with all applicable state and federal laws and regulations.

7.2 Records Retention

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C.Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107]. Records must be retained for a period of at least five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107).

Copies of records must be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

8.0 Policy Implementation and Update Information

Original Effective Date: August 1, 1977

Revision Information:

Date	Section Updated	Change

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Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Providers should select the procedure code that accurately identifies the service performed, and contact the fiscal agent to check service coverage or prior approval status.

Procedure codes requiring prior approval (this list may not be all inclusive):

CPT Code	Description
21076	Impression and custom preparation; surgical obturator prosthesis
21077	Impression and custom preparation; orbital prosthesis
21079	Impression and custom preparation; interim obturator prosthesis
21080	Impression and custom preparation; definitive obturator prosthesis
21081	Impression and custom preparation; mandibular resection prosthesis
21082	Impression and custom preparation; palatal augmentation prosthesis
21083	Impression and custom preparation; palatal lift prosthesis
21084	Impression and custom preparation; speach aid prosthesis
21085	Impression and custom preparation; oral surgical splint
21086	Impression and custom preparation; auricular prosthesis
21087	Impression and custom preparation; nasal prosthesis
21088	Impression and custom preparation; facial prosthesis
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; augmentation sliding osteotomy single
21122	Genioplasty; augmentation 2 or more osteotomies
21123	Genioplasty; sliding augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material.
21127	Augmentation, mandibular body or angle; prosthetic material. With bone graft (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21141	Reconstruction midface, LeFort I; single piece segment movement in any direction (eg, for Long Face Syndrome), without bone graft

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CPT Code	Description
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21143	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21145	Reconstruction midface, LeFort I; single piece segment movement in any direction (eg, for Long Face Syndrome), requiring bone grafts(includes obtaining autograft)
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction (eg, for Long Face Syndrome), requiring bone grafts(includes obtaining autograft) (eg, ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction (eg, for Long Face Syndrome), requiring bone grafts(includes obtaining autograft) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
21151	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome) any direction, requiring bone grafts (includes obtaining autografts)
21159	Reconstruction midface, LeFort III; (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III; (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L ostomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L ostomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental;
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; augmentation, reduction
21210	Graft, bone; nasal, maxillary or malar areas; (includes obtaining graft)
21215	Mandible (includes obtaining graft)
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear; (includes obtaining graft)
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete

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CPT Code	Description
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21248	Reconstruction of mandible or maxilla,endostreal implant; (eg, blade, cylinder) partial
21249	Reconstruction of mandible or maxilla,endostreal implant; (eg, blade, cylinder) complete
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	Reconstruction of orbit with osteotomies and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
21260	Periorbital osteotomies for orbital hypertelorism with bone grafts; extracranial approach
21261	Periorbital osteotomies for orbital hypertelorism with bone grafts; combined intra- and extracranial approach
21263	Periorbital osteotomies for orbital hypertelorism with bone grafts; extracranial approach with forehead advancement
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts extracranial approach
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts combined intra- and extracranial approach
21270	Malar augmentation, prosthetic material
21275	Secondary revision of orbitocraniofacial reconstruction
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach

The following CPT codes no longer require prior approval:

CPT Code	Description
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-laterial orbital rims & lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm

CPT Code	Description
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Place of Service

Inpatient hospital
Outpatient hospital
Ambulatory surgery center
Office
Clinic

F. Co-Payments

Recipients do not pay co-payments for craniofacial procedures.

G. Reimbursement Rate

Providers must bill their usual and customary charges.